DEPARTMENT OF DEFENSE BLOGGERS ROUNDTABLE WITH VICE ADMIRAL ADAM ROBINSON, JR., CHIEF OF NAVY MEDICAL CORPS VIA TELECONFERENCE FROM IRAQ TIME: 3:05 P.M. EDT DATE: TUESDAY, OCTOBER 2, 2007

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CHARLES "JACK" HOLT (chief, New Media Operations, OASD PA): well, we can go ahead and get started. With us today on the bloggers roundtable Vice Admiral Adam M. Robinson, Jr. He's the surgeon general with the United States Navy, chief of the Bureau of Medicine and Surgery.

Sir, do you have an opening statement for us?

VICE ADM. ROBINSON: Well, what I'd like to do is, first of all, thank you all for having me here this afternoon and letting me participate. I've been the Navy surgeon general for approximately a month's time now, and I felt like this was one of the nice ways to actually get my message out to not only the folks in the -- in Navy medicine, but also the folks in the rest of the country, in terms of what I think is important about Navy medicine and actually about military health. I think that in my experiences the concept of care is crucial in military health service today. That concept of care is very simple, and that is, that we remain focused on the health and the needs of the individual service members and their families and that no matter what we do from a medical -- or a military health perspective and what we do from a medical perspective, we can never lose sight of the fact that we take care of patients. We need to provide care for patients, and anything that we do for patients should be done for them with the patient coming first and processes or administration coming after that.

And specifically I mean this: We shouldn't set up any kind of bureaucratic or process or administrative barriers that patients need to cross in order to gain the help and the care that they need. The same goes for their families. That's from my perspective as a surgeon and as a physician, as someone who's practiced Navy medicine for 30 years -- is a concept of care that we in Navy medicine have done, we in the military health service should do, and we should continue to do that as we progress into the 21st century.

The second thing I'd like to just simply say is that, the concept of force health protection -- force health protection's a fit and ready force, it's to deploy with the war fighters; it's been to care for the war fighters no matter what that care may be. And the reason I emphasize that point is, that care could be trauma services, but it may be preventative medicine, it may be OB, it may be pediatric infectious disease. There could be a variety of different things that we may need to do at any given time, so we need to be ready and able to give that care. And finally, we need to make sure that we

take care of eligible family members and those who have worn the cross of the nation because it is our honor and privilege and it's our duty to care for them.

The reason that that's important is that the ability to be ready to care for the trauma victim as well as the pediatric humanitarian assistance person requires me to have a very robust medical system on the direct care side, meaning military treatment facilities, so that I could have a platform whereby my physicians, nurses and Medical Service Corps officers and my corpsmen are trained to go out and to do their work.

So with that said, I'll open up to your questions. But I think it's very important -- those two points to get across, that is, the concept of care and then the force health protection mission of the military health system and of Navy medicine.

MR. HOLT: All right, sir. Thank you very much.

David.

(Pause.)

David, are you -- are you with us? (Chuckles.)

Q Your David or David Axe?

MR. HOLT: No, you -- David Mays.

Q Oh, okay. David Mays from American Forces Press Service, Admiral. I was wondering what you're doing on a daily basis to solve problems that -- you know, retires or others who seek just very basic care in medical facilities such as Walter Reed or Bethesda who have difficulties making appointments who may have difficulties filling prescriptions -- just everyday care. What is being done to improve that care?

VICE ADM. ROBINSON: That's a wonderful question. And the reason that I think it's a great question is of all the questions I've had recently, that's the one that I feel least able to answer in this regard: There's absolutely nothing that I've done from a commander's perspective, meaning a military health care commander perspective, as I did at National Naval Medical Center to answer that question directly.

But let me take it and say that all the work that I do at BUMED, everything that I do in order to try to facilitate health care needs of our members revolves around this particular process.

When I was the commander at National Naval Medical Center, your question actually went to me calling in pharmacy or calling in patient appointing or calling in a particular aspect of hospital and actually asking them if they could help, et cetera.

Now that I've gone to the next level, what I have to do is and what I've been involved in is daily meetings at Health Affairs, at TRICARE Management Association, TMA, at the OPNAV level to suggest to people that in order to deliver the benefit that I talked about with force health protection, I have to be capable of having a force that feeds career paths. In other words, the men and women of Navy medicine, in order to get them ready to do the readiness mission, they have to actually have patients coming through, from

eligible family members to retirees, who represent many of the patients that you're speaking of that need that very basic care. And I'm not talking just on the physical side. I'm actually talking on the pharmacy side and on the laboratory side and all of the ancillary care that people may need.

From that point of view, I need to make sure that I have the right force in fact involved in that, that I have the right budgets, that I have the resources that I need to keep my MTF open and vibrant and to make sure that my physicians and nurses and corpsmen and Medical Service Corps, ancillary medical support personnel have a base upon which they can in fact become ready so that I can place them in operational spots around the world and they can do those missions.

By the way, those operational spots, in addition to Afghanistan and Iraq, include Horn of Africa, and they also include humanitarian assistance missions such as USNS Comfort and also the USS Peleliu that has been out in the South Pacific.

So in a very roundabout way, there is nothing directly that I'm giving to those people who are having problems getting prescriptions filled at Bethesda or Balboa. But I can tell you from a resource- sponsored perspective, as the surgeon general of the Navy, I'm looking very hard at resources, both of the fiscal type, of the materiel type and of the personnel type, to make sure that I have the right forces and the right resource blend so that I can in fact deliver the benefit and keep a ready, fit force.

Q Okay, thank you.

VICE ADM. ROBINSON: You're welcome.

MR. HOLT: Okay, sir, you mentioned the right force and then that blend of forces, or the blend of resources. Are you having any problems finding the right people, the right recruits for the medical billets?

VICE ADM. ROBINSON: Well, I think that the answer is, we're having problems in finding certain types of recruits. For example, it is very difficult to get enough psychologists, clinical psychologists, and even psychiatrists. Because right through here, the number that are being trained and the number that are available to the military are very limited. So yes, that becomes a problem.

Right now also, I think, on the nursing side and on the corpsman side, we have now particularly a problem. Particularly on the nursing side, we have some new recruiting packages and bonus packages in place that I think have made -- have mitigated some potential needs and problems. So that's actually become a lot easier.

On the medical corps side, I have physicians that are leaving after their first term of service at a higher rate than I would like. And it's become very difficult to attract them and to keep them with us, both from the Health Professions Scholarship Program and also, after they've gotten into the HPSP and they've finished their first term, many are electing to leave rather than stay with us, do their training and continue service.

I think part of that is because of the war, but I think most of that is because they don't see career paths that are open to them on the military side. In other words, if they're looking at graduate medical education, if they're

looking at residency training, if they're looking at then going and doing their mission, let's say, as a surgeon or as internal medicine internist, and then coming back and doing refresher training and then going back out, often they don't see that -- a career path that establishes that credible time for them in the military.

So these are issues that I think all the services are facing, Army and Air Force. Certainly I'm speaking for the Navy today. These are issues that we have to keep in mind. And they are not all solved today, but that's part of my mission as surgeon general, to go out and look at what needs to occur from a mitigation point of view and from a total force point of view, to make sure that we have and can attract those people, get them here and keep them.

In the military we talk about recruiting an individual and retaining a family. And that's very important, because in addition to making sure that the military member comes in and that he or she enjoys their professional development, I have to make sure that there's a personal development that occurs and even perhaps a spiritual development that occurs.

The personal development has to do more with the family, and that -- and I tell my folks all the time, my active-duty members, professionally, we're going to give you the best training in the world. Personally, you have to make sure that you are scheduling time for yourself and for your recreation and for your family, because it's not something that automatically happens.

And then from the spiritual point of view, my thoughts there are very simple. It's not a religious message. It's just a message to say that there's more in life than you, and you need to be respectful of that. And if you could work that triad in such a way that benefits you, you're going to be full-up round to go out and do the job that we need on the military medicine side.

So I think that that's very important. Those are some of the issues that we're facing in the MHS and in Navy medicine.

MR. HOLT: All right, sir. Could you speak to us a little bit about the multidisciplinary care teams that you've got in place at Bethesda?

VICE ADM. ROBINSON: Yes, I can. And the multidisciplinary care team is a refinement of a trauma construct, the trauma surgery construct. My background is general surgery, and then I did a subspecialty in colon and rectal surgery. So as a surgeon, I'm very much interested in and have studied throughout my career the trauma surgery construct of how you take care of people. And that construct is actually a multidisciplinary team construct. Let me explain it to you.

The trauma surgeon takes care of the individual's wounds and his body needs, but there may be many other surgeons that have to become involved, because as a trauma surgeon, I may do one particular type of surgery, but there may be ear, nose and throat or neurosurgery or orthopedic surgery or other injuries. But one person needs to be in charge of that patient, so that we can coordinate care and actually give the patient and the family member the care that they need and the information they need. So it's a way of deconflicting disparate questions and also disparate answers coming back from the medical professional.

Now here's the second part. In addition, particularly from the wounded warrior perspective at National Naval Medical Center, very often people are

wounded, and they are transported back to in-theater hospital care, then to Landstuhl and then to National Naval Medical Center or to Walter Reed within a matter of hours and certainly days.

So there becomes a real issue of time. When we have that much occurring, patients coming that rapidly, we have to be prepared to do a number of things. One of them is to also take care of their families.

So in terms of multidisciplinary care, we not only look at the patients and the family, we not only look at the patient's injuries and the medical care, but we look at making sure that all of the other care needs for the patient and the family are also looked at and coordinated. That includes chaplains. That includes case managers. That includes occupational or physical therapists. That includes psychologists and psychiatrists. It includes all of the care team that would be involved in that patient's care and that has to also help with the patient's family. Most of the time the patient's family needs information -- (audio break) -- the same type of information that the patient is receiving.

So it's a way of making sure that in a multidisciplinary fashion we can do a comprehensive look at a patient, take care of the patient and explain to the patient and the family what we're doing, and that the patient doesn't receive several different points of view but they receive one point of view; because we actually have a multidisciplinary team that is three times a week meeting as a multidisciplinary team and going over every patient and their needs.

MR. HOLT: Interesting. Okay, sir. Thank you very much.

Did somebody else just join us? (No audible response.) Okay.

VICE ADM. ROBINSON: Or somebody left, perhaps.

MR. HOLT: Yeah, somebody may have dropped off.

Anyway --

VICE ADM. ROBINSON: (Off mike) -- until we can stay there, okay? (Laughs.)

MR. HOLT: (Laughs.)

Q Hey Jack, David Mays again from American Forces Press Service. I have another question if it's appropriate.

MR. HOLT: Sure. Yeah. Q Admiral, I know that your campus there at Bethesda will be greatly expanding when Walter Reed closes its door and the new Walter Reed National Military Medical Center opens at Bethesda in September 2011. I wonder what you're personally doing to help prepare the Army, Navy and Air Force medical teams for that move.

VICE ADM. ROBINSON: Well, the -- for three years I've been involved with the BRAC and the closure of Walter Reed and, actually, the closure of the National Naval Medical Center, and the development of the new National Military Medical Center at Bethesda campus. I think that there has been some really great initiatives, particularly over the course of the last three weeks, and that has to do mainly with the standing up of the Joint Task Force CapMed in the national capital area led by Rear Admiral John Mateczun.

And the reason I think it's important is because there now is a unity of command that exists between the Army, the Navy and the Air Force in the national capital area. Those assets -- both from the Walter Reed campus and from the National Naval Medical Center campus and also from Malcolm Grove, the Air Force -- have come together under one unified command -- that's the JTF -- and we have now gotten a staffing plan. We now have a lay down of facilities. We now have a lay down and a sequencing of potential construction. And there's been great efforts to making sure that we can be -- to get a schedule that works, we can get the right people there, and that has been approved at the OSD level as of last week.

So I think that the joint task force coming in -- again, under Admiral Mateczun's care -- has been an excellent leap forward for the BRAC initiatives in the NCA.

As far as preparing people to go into the new National Military Medical Center, I think that that preparation is the preparation that we do now in terms of how we relate to one another in theater, how we relate to one another in a variety of different military medical associations, in which it takes more than any one service to get the job done. So when I'm looking at the USNS Comfort, I will note that there are a number of Navy people there and the majority are Navy, but there are also Air Force and Army personnel involved in that. There are also some other governmental service personnel involved in that. And then there are also nongovernmental affiliations that are helping to do that particular mission.

So I think that the military health system has a long history of doing joint and collaborative medical missions, and I think that this becomes another method. And actually I think it's a really wonderful way of showing what we can do as a joint medical facility in the NCA at delivering the force health protection benefit.

Here's the last point. No matter what we do -- and this is why I started out talking concept of care. No matter what we do and no matter how we do it, the concept of care goes like this. We have our joint task force issues, we have our Navy medical, our Air Force medical, our Army medical issues, but at the end of the day, it's the patient and the patient's family that comes first.

And in Navy medicine, what our tradition has been is to make sure that we put patients and health first, family first, and then we wrap everything else around them. We take all the bureaucracy and administration to the patient. We don't make the patient go to the process and the administration. And I think that's very important in terms of how we get things done. And that's how we've done it at National Naval Medical Center, and I would offer that as something that I would be very in interested in making sure we continue to do as we get more joint, as we do the National Military Medical Center and as we do more joint operations.

MR. HOLT: Thank you, sir.

And you mentioned the missions of the USNS Comfort. Could you speak a little bit about that? It seems to be one of the issues where they're out on the forefront of some of our public diplomacy efforts around the world, and especially with your latest mission, around the -- around South America. Could you speak to us a little bit about the Comfort, sir?

VICE ADM. ROBINSON: Yes, I can.

Comfort -- you know, I'm going to take you back to 1986, 1987. You know, I'm going to have to actually pin that date down, because it was Admiral Ace Lyons, who was the commander of the Pacific Fleet, that actually got the USNS Mercy, which was at the time, I think, at Oak Knoll -- or, excuse me, at Balboa. But personnel from Oak Knoll, personnel from Balboa -- Oak Knoll was in Oakland, California. That medical center has since closed. But personnel from both of those Navy medical centers deployed to USNS Mercy and then went to the Philippines for a very large humanitarian assistance visit, and it was very successful.

And the reason I bring that up is, that was the first -- at least in my memory, and I was on active duty then, but I don't remember any other humanitarian assistance mission in that time period. And then 25 years later or thereabouts, we do it again in USNS Mercy going to Banda Aceh in Indonesia and finding out that winning the hearts and the minds of the people using non-kinetic, using soft power, using medical and dental care, using those things that most of the time were not thought to be of great -- I don't want to say value to the world, but they just weren't thought of as being as useful as the kinetic. And in fact, I think that we really showed that we could win the hearts and the minds of many people who had had a different view of the United States and exactly who we were, and certainly who our military was.

With that in mind, the USNS Comfort has deployed to South America. It has gone through -- I keep saying South America, but it's actually Central America and the Caribbean -- it's gone through several countries, it's seen thousands and thousands of patients -- I think we're well over 100,000 patients at this date -- and has been a wonderful way for the United States, again, to show the flag and to show how much we care and how much we are invested in the well-being of peoples of other countries.

So again, it becomes a huge diplomatic resource for the United States and it becomes a very valuable aid in the lives of many people who can benefit from the humanitarian assistance, medical and dental care that they receive from the staff of the USNS Comfort, again which is made up of military and nongovernmental organization personnel.

I think that the Navy has seen the benefit of humanitarian assistance missions, and I think that it is certainly -- it has certainly become a strategic initiative from the OPNAV standpoint to make sure that we include humanitarian assistance and perhaps disaster relief missions in our Navy mission portfolio for the future because it makes a huge difference in how we care for peoples around the world and how we also take care of ourselves.

So this has been a great benefit, and it also expands the force health protection mission that I talked about, because we've often thought of that as being the trauma surgeon in the battle or from the battlefield, but now we need to think in terms of the humanitarian assistance and the pediatrician and the infectious disease and the family practitioner and the internal medicine doctor treating diseases and other things that are, again, not trauma related but are disease related, and things that we can have a great impact in and actually have great benefit for people.

So it's a huge area and one that I'm very proud to participate in, and men and women of Navy medicine are very proud to also participate in our humanitarian assistance missions.

MR. HOLT: Excellent.

Are there any follow-up questions? (No response.)

All right, sir. We've just got a few minutes left here, sir. Do you have any closing comments for us?

VICE ADM. ROBINSON: Well, I appreciate the time that you've taken today to go over those things that we have. I think that my closing would simply be that the healing process that must occur for our wounded warriors is something that begins on the battlefield when they're wounded and my corpsmen attend to them.

It continues in theater as they're taken to the medical treatment facilities that are closest to them and they get the trauma care and the emergency surgery and care that they need as they're casevaced to Landstuhl. It continues as their families arrive, sometimes before they do, at National Naval Medical Center or at Walter Reed.

And at National Naval Medical Center, we make sure that the care of the patient and the care of the patient's family is paramount in everything that we do, because if we can get that right, the other things seem, from my perspective as a physician, as a surgeon and as a medical administrator, the other things seem to fall into place. And what I mean by that is if I can keep my eye on the ball, and that is health care, people, patient, family, then I can always get the administrative or the process problems cared for and done. But if I get caught on the process and I miss the patient, often I've really missed everything, because if a patient is not cared for properly, then their process of healing is interrupted, and they're not going to be capable of being productive citizens back in the civilian communities, which is our goal to get them to.

Once you're wounded, I can never guarantee you'll be back to the same, but I can try my darnedest to make sure that you are as good as you can possibly be and then get you back into your communities so that you can become a productive, vibrant part of that community and help the United States understand exactly what the cost of freedom is from a very personal point of view.

So with that, thank you all very much for the opportunity to talk with you this afternoon.

MR. HOLT: Thank you, sir. We do appreciate it. And hopefully, we can speak again.

VICE ADM. ROBINSON: Well, you set it up. And (the CITO ?) is here, and I'll be happy to come back and talk to you some more.

MR. HOLT: All right, sir. Thank you very much.

Q Thank you, Admiral.

VICE ADM. ROBINSON: Thank you very much, everyone.

MR. HOLT: All right. Bye-bye. END.